DOCUMENT RESUME

ED 270 654 CG 019 107

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TITLE A Public Health Initiative for Preventing Family Violence.
PUB DATE 18 Nov 85
NOTE 12p.; Paper presented at the Annual Meeting of the American Public Health Association (113th, Washington, DC, November 17-21, 1985).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Battered Women; Child Abuse; Children; *Community Health Services; *Family Violence; Intervention; *Nurses; Police Action; *Police Community Relationship; *Prevention; *Public Health; *Referral

ABSTRACT

A community task force studying violence issues closely examined police statistics for domestic calls. Few records of referrals were made in response to these calls. Other statistics on child abuse and family violence reinforced the fact that family violence was a significant problem, making program response to family violence issues a top priority for the community. The community group developed methods to improve the opportunity for optimum growth and development among children at risk for child abuse and neglect. A police referral system between police and public health workers was arranged and the issues of confidentiality, power, and timeliness of contact were resolved. Other potential referral sources were contacted including a hospital-based family counseling program. Public health staff participated in staff development education on the topics of assessment, interview, and intervention techniques. Community awareness of family violence was heightened through sensitive plays on child sexual abuse, a brochure containing a service directory for police to give out on domestic calls, and a brochure on a non-threatening approach to parenting. Referrals have included domestic disputes, neighborhood disputes, severe psychological or mental health problems, chemical dependency, vulnerable adults, and needed home care. Most contacts made by the public health nurse were met with relief. Protecting and preserving the health and safety of people is in the public interest, and public health nursing needs to promote funding in areas not likely to generate fee for service revenues. (ABL)

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American Public Health Association
Washington, D.C.

A PUBLIC HEALTH INITIATIVE FOR PREVENTING FAMILY VIOLENCE

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November 18, 1985 - 2:00 P.M.

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The family violence prevention program in Bloomington, Minnesota is a cooperative arrangement between the city's public health services and public safety department. Police officers make an assessment of domestic calls based on certain criteria, and then have the option to refer to a public health nurse for follow-up.

The APHA theme this year, Government's Responsibility and the People's Health, seems especially appropriate when considering the issue of violence. Public health nursing has been dealing with violence within families since Lillian Wald established the role of the visiting nurse nearly one hundred years ago. We have come a long way in providing legislation and resources to help deal with child abuse and spouse abuse, but primarily after the abuse is substantiated. Prevention in areas such as this have always been difficult and elusive, particularly in assessing outcomes since changing behavior through education can take a whole generation to show any impact.

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An alliance between public health and safety is a natural for looking to early identification and intervention. Both have the same public interest charge within the social contract of government, preserving and protecting the health and safety of the people. Health and safety is intertwined and inseparable in protecting people in violent relationships and preventing domestic abuse. In Bloomington, a relationship between the police and public health nurse had developed by virtue of location when, in 1960, the two departments were housed together in an old house where City Hall now stands.

The City of Bloomington is a large suburb south of Minneapolis. Just forty years ago, the unincorporated thirty-nine square miles which comprised the township was primarily farm land with a population of less than 4,000 people. The post-World War II era changed all of that rapidly. Bloomington represents an almost classic example of urban sprawl in the '50s and '60s. The township incorporated as a village in 1953 at 25,000 population, and in 1960 at 50,000 population adopted a home rule charter as a city. It has grown to 83,000 today.

Edina and Richfield, two suburbs representing another 84,000 population, separate Bloomington from Minneapolis and contract with Bloomington for public health services. Public health services in Hennepin County, where we are situated, is politically complex. Minneapolis has had a strong health department for over one hundred years. Although there are forty-seven independent municipalities within the County, there was no County Health Department organized until 1977.

The State of Minnesota passed the Community Health Services Act in 1977, which facilitated the county organization but allowed the cities with organized health departments to remain independent.

Edina and Richfield are governed by City Councils which are also their Board of Health. According to the State law, in order to receive the subsidy, a two-year plan must be filed after a needs assessment is completed. All three cities have the characteristics of pure suburbs with no really distinct downtown areas. Each has several shopping areas and a good base of industry and commerce, but is primarily residential. All three have relatively low poverty rates. The average income ranges generally above the norm. Each city has its own police department.

In developing the two-year plans for each city, coordination is essential. Each city has its own distinct characteristics and there is a very strong sense

of individual community. That is, most people who live in Bloomington do not identify themselves as living in Minneapolis, Edina, or Richfield. Edina residents are the most affluent of the three cities and probably have the strongest identity with their city. It is important to understand these political complexities to appreciate the uniqueness of the area.

At the same time the planning process for the 1984-85 health plans was set in motion, the family violence issue was emerging as a priority in several ways. We had a long standing relationship with United Way for funding of health education, primarily focused on teen-age pregnancy prevention programs. This area was in their highest priority area for funding. In 1983, family violence was added to that list of top priorities. Locally, a task force had been formed in the South Hennepin area, which included our cities, to study violence issues. Some of the participants on the task force had strong ties with the State Domestic Abuse Project which fosters the development of local shelters and advocacy groups.

The planning process is a comprehensive needs assessment, which includes defining gaps and requires active participation of community members. In identifying the needs and gaps, all of these events began to come together within our planning process and served as a blending factor in developing a coordinated approach to the problem in our area.

One of the factors we chose to look at closely in identifying the local need was the 1982 police statistics in each of the cities identified as "domestic calls." These calls are generally defined as resident calls for family or neighborhood problems. The statistics were mostly numbers only and 99 percent of the calls had no written records. Almost no referrals were made except those that were identified as actual abuse and required reporting to welfare or involved arrest.

The 1982 statistics, however, were revealing because they were at least separated into categories of threatened or actual physical abuse. A total of 1,723 domestic calls were recorded. The breakdown for the cities was as follows:

Bloomington	800 domestic calls
	240 threatened or physical beatings
	80 spouse abuse
Edina	291 domestic calls
	27 evidence of violence
Richfield	633 domestic calls
	6 assaults by family members
	10 physical abuse

All of the other statistics on child abuse and family violence available on a county, state, and national level reinforced the fact that family violence in our affluent communities was indeed a significant problem. The Advisory Boards of Health, appointed within each community by their City Councils, were asked to review the materials and prioritize the focus of public health services for the 1984-85 plans. They all rated the goal of assisting in the development of a program to respond to family violence issues in South Hennepin as a top priority.

The group associated with the Domestic Abuse Project within the study task force began plans for a battered woman advocacy program. There were no shelters in the immediate area, and the shelters in the Hennepin County area usually had a waiting list. They assessed the need for founding a shelter, but financially this could not be a reality for some time. Working with them, we agreed we would focus on prevention issues and they would focus on advocacy issues.

United Way's priorities for funding were consistent with our focus.

1) The problem is serious and extensive.

2) Financial resources are inadequate.

3) There is no government mandate.

4) United Way funding can have an impact.

We chose to focus on a goal that would improve the opportunity for optimum growth and development among children at risk for child abuse and neglect. The methods we chose were:

1) to maintain and nurture a referral system of appropriate domestic calls from our local police departments which would reduce the need for recurrent police calls, providing timely family support and tap into the ready made source of identification of potential high risk families within the domestic calls made by police officers;

2) strengthen the collaboration of the service system in South Hennepin by working closely with the emerging advocacy group by increasing awareness of services and increasing referrals of residents at risk; and

3) enhance the intervention skills of the public health nursing staff to identify risks for child abuse and neglect, provide new intervention skills, and give nurses the confidence to deal with an issue generally considered risky and usually identified as within the Social Services realm.

Development of the project involved four major components and resolving issues within each component.

COMPONENT 1. DEVELOPMENT OF THE POLICE REFERRAL SYSTEM

It was decided to pilot the project in Bloomington because of the already existing close working relationship. As I mentioned earlier, police and health had shared quarters in the early '60s, and a long standing informal referral system had been maintained. The police chief was very receptive to exploring the concept and police officers found the idea of follow-up attractive. Many

officers expressed strong support for intervention since domestic calls left them with a feeling of helplessness unless an arrest could be made. A task force with key players was formed consisting of a police captain, a patrol officer, the police chaplain, the city attorney, and a member of the advocacy group recently formed, called Cornerstone. A major issue to be resolved was confidentiality. The legal opinion handed down was:

"While the data included in police reports of domestic disturbance is generally public," the exceptions are:

1) data pertaining to victims of criminal sexual conduct or intrafamilial sexual abuse;
2) investigations pursuant to the Minnesota Domestic Abuse Act; and
3) information collected for purposes of preparing a criminal or civil case.

This criteria indicated that the only cases which could not be referred were already being responded to within the legal system.

Another issue surrounded power. Police had to be convinced that this was not giving up control and that filling out a form could possibly reduce the rate of repeat calls. Another power issue that evolved with the clearance of the confidentiality issue was the advocacy group wanting all referrals and looking on our project as a threat to the success of their project. We used the approach of pursuing mutual interests, and there was the realization that they would have more to gain by having a public health nurse stick with the mother in the process of getting ready to make some changes in a violent relationship than there was to be lost.

The third issue of timeliness was resolved by recognizing that our services would not be an emergency service. Contact was agreed to be made within a week after the actual incident to assess what problems still smoldered

and look at underlying causes.

COMPONENT 2. RESOURCE LINKAGES

Numerous contacts and meetings were held with other providers to gain support and understanding of the program and clarify roles and the referral process. We aligned ourselves with the local hospital's Family Renewal program which provides indepth counseling for families, and agreed to use them as a major referral resource for individuals with resources to pay for the service.

COMPONENT 3. STAFF DEVELOPMENT

We contracted with the Family Renewal staff to provide an indepth inservice on family systems to our staff. Heavy emphasis was based on assessment, interview, and intervention techniques. A part of the agreement included using them as a back-up resource for families without resources to use their service.

The women's advocacy group acted negatively to our family approach because they believed the family system theory promotes abuse because it tells the victim that they did something to cause the abuse, virtually blaming the victim.

We spent a good deal of time with the advocacy group separating the cause and effect. We reemphasized our primary focus of early identification, intervention, and prevention. The need to identify the multiple risk factors in a family system was pointed out as a key to modifying the situation in order to work for change.

The risk factor in family systems for child abuse and neglect were identified as:

Demographics - age of parent
- marital status
- number of children
- employment
- family background

Mental health

Stress management

Substance abuse

Relationships - support systems

Resources

COMPONENT 4. COMMUNITY AWARENESS

To overcome the myth of immunity from family violence in affluent suburbia we needed to increase awareness locally in addition to the local newspaper. A performance of the "Touch" continuum was sponsored. It is a series of sensitive plays dealing with issues of child sexual abuse. Along with the performance we combined it with a service and resource fair. It was well attended, and each performance attracted large crowds of parents and their children. It was advertised in all the schools, and they encouraged attendance.

We produced and cosponsored a brochure with the advocacy group for police to leave in the homes when making domestic calls and a mini directory of services in the area. In addition, we produced our own brochure with a non-threatening approach to parenting, recognizing that all parents should be able to access public health services and not just parents experiencing problems brought to the police department's attention.

The first referrals began to flow in April of 1984 after inservices including video tapes for roll call at the police departments were completed. One officer in each department was assigned as a liaison to the Health Department and responsible for reviewing referrals to be sent to the Health Department. Although the original focus was child abuse and neglect, the police officers quickly expanded the range of cases referred for public health intervention.

In eighteen months we have received 246 referrals ranging from areas of

actual domestic dispute, not always including children, to neighborhood disputes, severe psychological or mental health problems, chemical dependency, vulnerable adults, and the need for home care because of disease or disability.

The referrals are made with the understanding that working with a public health nurse is strictly volunteer. The vast majority of contacts made by the public health nurse are met with immense relief. Often, the first telephone contact becomes a long phone call with the individual pouring out their frustrations in detail. Only occasionally does the nurse encounter hostility or a flat refusal to discuss the problem. A very small number of the cases referred were already known to our agency as participants in WIC, Child Youth Clinic, or another service area. The police referral shed new light on the case and helped the nurse to deal with previously unknown circumstances within the family.

A psychiatric nurse consultant has been retained to provide added support to the members of the family support team. Twice a month she meets with the nurses on the family support team and reviews cases, strategies, and interventions. She helps them to determine the appropriateness of the approach and identify the need for continued involvement or referral to another provider. She is available by phone at all times.

Police officers appreciate the feedback and express a strong support for the continuance of the program. The United Way chose to fund the start up of this concept in 1984 and has continued and increased its funding.

Cases of actual abuse are often identified by the nurse after the referral has been made and the Cornerstone Advocacy Program receives referrals from us on a regular basis. By the same token, they have found the nurses' skills are of value to them and, in turn, refer families to our services.

At the end of the first nine months an informal evaluation was done with the participants. The response showed that 62 percent were either very

satisfied or satisfied with the intervention. Only 10 percent felt it was not helpful. The nurses all feel the experience has been very rewarding and express new confidence in dealing with areas previously felt to be scary or outside of the public health nursing realm. Some individuals served through this project have taken the time to call or write to me in appreciation of help they received.

One in particular, a family with multiple risk factors who had been through numerous agencies and interventions, stated it was the first real help and insight they had received. They further stated the nurse's calm, down-to-earth common sense and real interest in helping them was like a breath of fresh air and opened a whole new perspective on the situation for them.

In closing, I would like to make a few observations about public health and public health nursing from a twenty-nine-year perspective in the field. In 1957, when I began my first county nursing job in "rural Hennepin County," I was ill-equipped to deal with issues of violence. I remember my first encounter vividly. It was a young mother with five children under seven expecting her sixth. She always had a lot of black and blue marks and lots of excuses, such as falls off ladders. She finally admitted her husband had a temper and swatted the kids around when he was irritated. She could depend on a beating if she yelled at him to stop hitting the kids. She said her priest and parents told her she could stop it if she kept the house cleaner and the kids out of his way. I remember being angry about the situation but feeling helpless. It was pretty much accepted then that wife and child beating were a husband's disciplinary preogative as long as they weren't too disabling.

As I stated earlier, preserving and protecting the public's health and safety is our public charge. During the past two decades we have been forced to justify our existence by concentrating on collecting fees for service. Medicare has given public health nursing a really mixed bag of blessings and

woes.

I think it is time we reassess what the public in public health really means. I believe it means government, government in the sense that John Locke, the 17th century English philosopher, asserted. He theorized that government forms the social contract of the people living within a state, and that the social contract should be guided by natural rights. This plea for democracy bore fruit in our U.S. constitution. The writers of our constitution considered John Locke to be the father of reason.

Protecting and preserving the health and safety of people from violence is clearly in the public interest. Public health nursing needs to take a strong stand to support funding in areas that aren't likely to generate fee for service revenues, but are clearly government's responsibility for the people's health.